Ageing, Health and Disability

Hajiya Hosabe was always busy. She gathered herbs and made her own medicines, treating women and children for various illnesses. A skilled midwife, she helped deliver babies. She sold henna, which the women use as a cosmetic. She often travelled to visit relatives, and in the last ten years had made three trips to Mecca. At age 80, she was an active and highly respected member of her community in Nigeria.

The World Ageing Situation 1991, United Nations

Hajiya Hosabe is the living proof that old age does not equate with illness. Many of the aged have major health problems; many do not.

Studies of the elderly in industrialized countries indicate that health and well-being are similar among the elderly in different nations. These studies show that a large majority of the elderly are in good health, with no significant mental or physical decline. Only about 8 per cent of older people are seriously impaired or dependent on extensive health care, with 4-6 per cent living in institutions for the elderly.

There is much less information about the health of the elderly in developing countries. But a 1986 survey of the World Health Organization (WHO) in Fiji, Malaysia, the Philippines and the Republic of Korea provides similar insights. For example, as in industrialized countries, a large proportion of the elderly reported that they felt healthy: 50 per cent in the Republic of Korea, 58 per cent in Fiji, 72 per cent in Malaysia and 84 per cent in the Philippines.

Ill and disabled persons

But in all countries there are also significant numbers of the elderly with disabilities and health problems. The most pressing and treatable health problems of the elderly throughout the world are related to heart functions, hearing, teeth, diabetes, visual impairment and osteoporosis.

For instance, in the United States hypertension is the most frequent health problem among people aged 65 and over, followed by hearing impairment, heart conditions, visual impairment and diabetes.

Cardiovascular disease was also the most common problem in the German Democratic Republic, Hungary, the Soviet Union and Yugoslavia, a 1982 study revealed.

Among developing countries, malaria is a major cause of impairment or disability. Eye diseases such as cataracts, glaucoma and trachoma underlie visual disabilities in these countries.

The 1986 study on Fiji, Malaysia, the Philippines and the Republic of Korea confirms the findings of other surveys on the high incidence of vision problems among the elderly in developing countries. Between 31 and 82 per cent of the elderly in the four countries had problems with vision.

Much of the blindness among the elderly in developing countries can be prevented or cured with existing knowledge and technology. A great deal can be done with relatively small expenditures.

For instance, in Malawi where preventable and curable blindness affects about 1 per cent of the population, a national public programme is extending eye care services to rural communities. Mobile eye units are reaching rural people, providing treatment, education and referral services. Before doing anything else, the personnel of the mobile units give a lecture on preventive and primary eye care to the local inhabitants. Then patients with acute problems are treated, and those with serious problems are referred to hospitals.

UNITED NATIONS

An increase in disability?

Today there are nearly 500 million older people (aged 60 and above) in the world. By 2025, the elderly are expected to number 1.2 billion. Worldwide, nearly one million people cross the 60-year threshold every month.

With the general increase in life expectancy, more and more people are surviving to older ages. For the industrialized countries, male life expectancy at age 65 has increased 1.6 years on average since 1960. For females, the gains in life expectancy at age 65 have been even more impressive, rising 3.3 years over the same period.

But a longer life does not always mean freedom from disability, according to WHO's 1991 Report on the World Health Situation. Although life expectancy of the elderly has generally increased, it is not at all clear whether sickness and disability have declined in parallel with mortality rates, the report says. Available evidence suggests that the extra years of life that have been gained in the past two decades have largely been tarnished by disability, which reduces the quality of life and increases the demand for health and social services.

The major causes of disability among the elderly include arthritis, deafness, blindness, Alzheimer's disease and related neurological disorders. To these may be added the mental problems caused by social isolation and depression.

The family and the community

A WHO report, "Health of the elderly", underscores that informal care is all over the world the main form of assistance for the elderly. Although the use of formal services is growing, the family continues to be the mainstay of care. Women still provide most of the informal long-term care. And many of the family care-givers are themselves elderly.

This is particularly evident in most developing countries, where the family remains the only source of support and long-term care for the elderly. An extended kin network, in which parents, children, uncles, aunts and other relatives are in regular contact, is the core of the traditional welfare system. The family feels collective responsibility towards all household members, old and young, strong and weak. Caring for the elderly and the disabled is an accepted and shared responsibility of all family members.

This attitude is not confined to developing countries. In Japan, more that half of the elderly people bedridden for more than six months were being cared for in their own homes by relatives living with them, a 1983 study revealed.

The rural-urban exodus, increasing participation of women in the formal workforce and other factors are reducing the numbers of family care-givers traditionally available for the now increasing numbers of the very old. These changing situations call for new levels and methods of joint family care as well as for governmental and non-governmental support.

Community services

Most older people much prefer to remain in the community as long as possible. Community services should thus be viewed as the first approach to providing services to those who need care, WHO recommends. Some elderly will require more specialized assistance, but should remain eligible for community services.

In fact the majority of elderly people are not disabled. Neither are they dependent on others, the WHO report stresses: they live in their own homes or in those of their relatives. Old age does not of itself indicate a need for specialistic care. The majority of health care of the elderly will therefore be in the form of primary health care.

In both developed and developing countries, most elderly people will continue to be treated by primary care practitioners within community-based programmes. Primary care workers should thus be educated to recognize and deal with common problems of the elderly.

The informal support system remains central, providing 80 per cent of the care for the elderly. The primary function of formal care is to help the informal system maintain older individuals in the community whenever possible. Special emphasis should be given to programmes that assist the family in its role of supporting the elderly. Community services such as day care and home-help services should enhance family care, WHO recommends.

Policies should strengthen both family resources and the motivation to continue caring for the elderly. In some countries, efforts are being made to compensate family members for the care they provide, with direct cash payments or the provision of the attendance allowances available for disabled individuals needing outside help.

Training and prevention

WHO also stresses the need for training and information. Family, friends and neighbours—the informal care-givers—provide the bulk of assistance for the disabled elderly living in the community, but usually receive little or no training.

Informal care-givers, who are typically middle-aged or even "young elderly", are greatly aided if they become better informed about the nursing roles they perform. What these people particularly appreciate is practical information from professionals on how to manage everyday problems.

There are several areas of preventive action for the elderly, WHO stresses. Some involve preventive strategies, such as immunization for flu and pneumonia and smoking cessation. Elderly smokers can greatly reduce their risk of lung cancer and heart disease by stopping even in their seventies. Another form of prevention is screening—for vision, hearing, cancer, blood cholesterol and the like.

Institutional long-term care should be provided only after other alternatives have been explored, WHO recommends. Institutional services should be provided in as homely an environment as possible, preserving the autonomy of the resident to the greatest extent possible.

Future outlook

With mortality rates decreasing around the world, the number of individuals over 65 is expected to increase severalfold over the next few decades. The challenge is to develop effective strategies to improve the quality of life for older people through an appropriate mix of services and care-giving approaches.

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